

Screening for Substance Abuse During Pregnancy

GUIDELINES FOR SCREENING

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Preface

Substance abuse during pregnancy has been identified as an issue critical to the health of mothers and babies from all socioeconomic groups. Since there are no defined safe limits during pregnancy, any use should be minimized. Substance abuse contributes to obstetric and pediatric complications, including Fetal Alcohol Spectrum Disorders (FASD),¹ prematurity, and abruptio placenta. Prenatal alcohol exposure is the leading preventable cause of birth defects and developmental disabilities in our country. Fetal Alcohol Syndrome (FAS) prevalence in the general population of the United States can be estimated to be between 0.5 and 2 per 1000 births and the prevalence of FAS and Alcohol-Related Birth Defects (ARBD) combined is likely to be at least 10 per 1000 or 1% of all births.²

Reduction of perinatal substance dependency and its devastating effects can be achieved through improved identification of drug use prior to or early in pregnancy and consistent utilization of evidence-based medical protocols. Early identification is the first step toward engaging substance dependent women into treatment. This aligns well with the Vermont Agency of Human Services goal on integrated service delivery for children and families. Primary prevention efforts in family planning and primary care settings, aimed at identification prior to pregnancy, are also of critical importance in achieving a significant reduction in perinatal drug use.

Treatment for substance abuse during pregnancy can be more effective than at other times in a woman's life. Health care providers play an important role in influencing the health behaviors of the pregnant women in their care. Pregnant women often describe their providers as the best source of information and generally follow their advice. We know that FASD and the deleterious effects of drugs are preventable. If we are successful, we will promote optimal health for children and their families, as well as realize substantial cost savings, including health care, foster care, special education, and incarceration.

We hope this booklet will help all health care professionals working with pregnant women enhance their skills and improve care for women and infants.

Wendy Davis, MD
Commissioner, Vermont Department of Health

Purpose

The American College of Obstetrics and Gynecology (ACOG) 2008 Committee Opinion number 422, *At-Risk Drinking and Illicit Drug Use: Ethical Issues in Obstetric and Gynecologic Practice*, and the ACOG Committee Opinion No. 343 August 2006, *Psychosocial Risk Factors: Perinatal Screening and Intervention*, recommends that all pregnant women be questioned thoroughly about substance abuse.

The purpose of this booklet is to:

- Improve provider ability to effectively screen and identify pregnant women with substance use/abuse issues.
- Provide guidelines for screening and follow-up.
- Provide sample screening tools.
- Provide recommendations related to drug testing of pregnant women and newborns.
- Provide referral resource numbers.

¹ FASD is the latest federally accepted umbrella term used to refer to all conditions caused by prenatal alcohol exposure, such as fetal alcohol syndrome (FAS), fetal alcohol effects (FAE), alcohol-related neurodevelopmental disorder (ARND), and alcohol-related birth defects (ARBD).

² May PA, Gossage JP. summary. Alcohol Res Health. 2001;25(3):159-67. Review.

Definitions

Use refers to any use of alcohol or illicit or non-prescribed drugs.

ABUSE is a recurring pattern of alcohol or other drug use which substantially impairs a person's functioning in one or more important life areas, such as familial, vocational/employment, psychological, legal, social, or physical. Any use by a youth is considered abuse.

DEPENDENCE is dependent use, which is a primary chronic disease with genetic, psychological, and environmental factors influencing its development and manifestations including physical/physiological dependence as evidenced by withdrawal. Psychological dependence is evidenced by a subjective need for a specific psychoactive substance such as alcohol or a drug. Women who abuse substances or are chemically dependent require different interventions than men.

ADDICTION OR ADDICTIVE PROCESS A complex, progressive behavior pattern having biological, psychological, sociological, and behavioral components. The addicted individual has pathological involvement in or attachment to a behavior (substance use), is subject to a compulsion to continue to use, and has reduced ability to exert personal control over the use.

SUBSTANCE-EXPOSED NEWBORN is one who tests positive for substance(s) at birth, or the mother tests positive for substance(s) at the time of delivery, or the newborn is identified by a medical practitioner as having been prenatally exposed to substance(s).

SUBSTANCE-AFFECTED NEWBORN is one who has withdrawal symptoms resulting from prenatal substance exposure, and/or demonstrates physical or behavioral signs that can be attributed to prenatal exposure to substances, and is identified by a medical practitioner as affected.

SCREENING Methods used to identify risk of substance abuse during pregnancy and postpartum, including self report, interview, and observation. All pregnant women should be asked about illicit, non-prescribed, and prescription drugs and should be screened for substance use, abuse, and dependency. Rescreening should be done if risk factors are present or if the woman has a history of alcohol or drug use.

TESTING Process of laboratory testing to determine the presence or absence of a substance in a specimen. Universal testing may be used as a screening tool in some practices but is not recommended. Patients should be informed about urine drug testing and have the option to decline testing.

ASSESSMENT Comprehensive evaluation of a client's risk for substance abuse during pregnancy and postpartum. The following are characteristics of assessment: includes collecting objective and subjective information; may include screening and lab testing; should be timely and culturally appropriate; may result in a diagnosis, referral, and plan for intervention.





Scope of the Problem

Substance abuse is found throughout all social and economic tiers. As prescription opiate use increases, more working and middle class women are affected. Women who use may show no social signs of problems and may be fearful of disclosure. The Department of Health & Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), made available the results from a 2006 National Survey on Drug Use and Health: National Findings. It was reported that among pregnant women, aged 15 to 44 years, 4.0% used illicit drugs in the past month, 11.8% reported current alcohol use, 2.9% reported binge drinking, and 16.5% of pregnant women used tobacco in the last month.² In the United States nearly 90% of drug-abusing women are of reproductive age. Substances most commonly abused during pregnancy include cocaine, amphetamines, opioids, marijuana, ethanol, tobacco, caffeine, and toluene-based solvents. Polysubstance abuse is very common.³ In Vermont, it is difficult to estimate the number of alcohol/drug-exposed and -affected infants. Accurate, population-based, available data sources are limited and often combine episodic use of alcohol and drugs with chronic addiction.

The Vermont Pregnancy Risk Assessment Monitoring System (PRAMS) is a survey of Vermont resident women who give birth in Vermont or New Hampshire. Included in the survey are questions about tobacco, alcohol, and drug use. In 2007, the most recent year for which PRAMS data are available: 68.7% of Vermont mothers reported drinking during the three months before they became pregnant, 22.8% of mothers reported binge drinking (five or more drinks on at least one occasion) in the three months before they were pregnant, 12.7% of women drank alcohol during the last three months of pregnancy, 29.6% of Vermont mothers smoked prior to their pregnancy, and 17.5% of mothers continued to smoke during the last three months of their pregnancy.

Vermont PRAMS data from 2007 indicates that 66.5% of mothers reported that their health care provider had discussed with them how using illegal drugs during pregnancy could affect their baby.⁴

² Substance Abuse and Mental Health Administration. Results from the 2005 National Survey on Drug Use and Health: National Findings. Office of Applied Studies, NSDUH Series H-30, DHHS, Publication No. SMA 06-4194, Rockville, MD, 2006.

³ Kuczkowski KM. (December 2007) The effects of drug abuse on pregnancy. *Current Opinion in Obstetrics & Gynecology*. 19(6), 578–585.

⁴ Vermont Department of Health, PRAMS, 2007.

The Role of the Health Care Provider

It is the responsibility of every practice to make sure that all pregnant and postpartum women are screened for substance use. Physicians, nurses, and others involved in prenatal care play an important role in the reduction of substance use during pregnancy. For clients who require intervention for substance use, a team approach is required from the primary provider, clinic nurse, social worker, public health nurse, chemical dependency treatment provider, and the client herself.

In order for the health care team to screen clients effectively, members of the team must be educated about when and how to screen, how to assist the woman who admits use, and about associated issues in the substance using/abusing woman's prenatal and postpartum care.

Universal Screening for Substance Abuse

Universal screening provides the practitioner with the opportunity to talk to every client about the risks of alcohol, illicit drugs, prescription drugs, tobacco, and other substances and risky behaviors. Structured screening, built into the care of every pregnant woman, helps eliminate "educated guessing," which is often reliant on practitioner bias and attitudes. With education and practice, the provider's skill and comfort with confronting these issues improves, interviewer bias is eliminated, and the stigma of substance use and abuse is reduced. The practice of universal screening increases the likelihood of identifying substance users and allows for the earliest possible intervention or referral to specialized treatment.

Screening is conducted by interview, self-report, and clinical observation. Screening takes only about 30 seconds for most patients who do not have a substance use problem and 5–10 minutes for the 10–15% of patients who do. This initial step actually saves time by answering questions that might come up later and by reducing care time for a patient in whom obstetrical complications can be prevented through early identification of this risk factor. In addition, screening and education of every client enhances public awareness of the risks of substance use/abuse during pregnancy and may prevent use/abuse in future pregnancies.

Urine Toxicology Not for Universal Screening

Urine toxicology may be useful to follow up a positive interview screen. For more information about the benefits and limitations of urine toxicology see page 10.

The American College of Obstetrics and Gynecology (ACOG) 1994 Technical Bulletin concluded that urine testing has limited ability to detect substance abuse and therefore does not recommend universal urine toxicologies on pregnant women as a screening method. In its subsequent Committee Opinion (2004), ACOG asserted that universal screening questions, brief intervention, and referral to treatment was the best practice.

Screening Tools

Interview-based or self-administered screening tools are the most effective way to determine risk and/or allow self reporting. Brief questionnaires have demonstrated effectiveness when screening for alcohol and drug use during pregnancy.

Use a screening tool with every client, not just those in whom substance use is suspected. Women should be screened for alcohol, illicit drugs, tobacco, misuse of prescription drugs and other substances, including use prior to pregnancy. *See Appendix A for examples of validated tools.* For further information, visit www.familydocs.org/drupal/files/UDTmonograph.pdf.

Trauma and Intimate Partner Violence

Recent addiction research has identified physical, sexual, and emotional abuse as frequent precursors to substance use in women; therefore, pregnant women should also be screened for risk of domestic violence.

By definition, trauma is a real or perceived threat to the survival of an individual, a support system, or a larger community or culture. Trauma is extreme stress that overwhelms someone's ability to cope. Trauma can include interpersonal violence over a life span including sexual abuse, physical abuse, severe neglect, loss, and/or the witnessing of violence. Trauma has been identified as having a co-occurring relationship with substance abuse and mental health in women. Women with a trauma history often turn to drugs and alcohol to kill the pain of their experiences.

Potentially, a provider may encounter a woman with a past or current experience which may result in her resistance or intolerance of treatment. The provider is in a unique position to consider and recognize these issues. Developing a sense of awareness and support could be critical in a pregnant woman's engagement in medical care and treatment.

See Appendix B for Intimate Partner Violence Screening Tool.

Ask

How to Screen

Screening is a skill, and staff should be trained in interview techniques. The screening should be performed by the health care provider or other staff member who has an ongoing relationship with the client. The results of the screen should be discussed with the client in a nonjudgmental, supportive manner and documented in the chart. If the client is screened by someone other than the primary obstetric provider, the provider should review the results of the screen and give appropriate follow-up messages to the client.

Make substance use screening a routine part of prenatal care services. This approach decreases subjectivity, discomfort, and bias. Ideally, pregnant women should be screened at each encounter, or minimally, once each trimester. Include inquiries into substance abuse problems in family members. Know how to respond to both positive and negative responses to screening tools. As trust develops, the client who is using is more likely to disclose that use. When use is disclosed, remember that screening tools identify risk but are not diagnostic. Know how to respond, including discussing risks of use, benefits of stopping, and resources for further evaluation.

Create a Respectful Environment

Supportive inquiry about use of drugs or alcohol can open the door to referral and treatment. In order to elicit an honest response, a safe and respectful environment is essential.

- Do not assume that all women know when they became pregnant or welcome the current pregnancy.
- Educate support staff about the importance of a positive and nonjudgmental attitude in establishing a trusting relationship and welcoming environment.
- Observe and protect provider/client confidentiality. For example, know the issues surrounding consent for testing clients and newborns.
- Ask every question in a health context. This lessens the stigma associated with the topic and expresses concern for the health of the mother and baby.
- Be empathetic, nonjudgmental, and supportive when asking about use; consider the client's needs and life situation.
- Offer culturally appropriate screening in the client's primary language.



Advise



Educational Messages for Clients

Assume that all women have some knowledge of the effects of drugs, alcohol, and cigarettes on pregnancy. Ask what the woman knows, then fill in the missing pieces and clarify misconceptions. This is an excellent opportunity to educate the client and her partner about the adverse effects of tobacco, drugs, and alcohol and the benefits of stopping use at any time during pregnancy or postpartum. These messages can be reinforced through pre-pregnancy, pregnancy, and postpartum discussions not only by the primary obstetric provider, but by the community childbirth educator, outreach worker, community health nurse, and other health care staff.

Assess

When a Woman Denies Use

Most women do abstain from drugs and alcohol, especially during pregnancy. Acknowledge this wise choice and review the benefits of abstinence from substances. Continue to screen throughout pregnancy and postpartum, ideally at each encounter, but at least once per trimester. In some situations, women may deny use, but a constellation of signs and symptoms suggest abuse. In this case it may be prudent to re-screen frequently or conduct lab testing.

When a Woman Admits Use

Most women are able to abstain during pregnancy, so the woman who admits to current use of significant amounts is likely to have remarkable addiction and may be using substances to help her cope with psychosocial stressors in her life. The woman may feel safe enough to share with the medical provider about her use but may not be ready to take the next step of a comprehensive assessment and treatment.

The **STAGES OF CHANGE** model developed by Prochaska and DiClemente (1992) is one approach to understanding the steps to changing drug or alcohol use during pregnancy.

- STAGES OF CHANGE:**
- 1. PRE-CONTEMPLATION**
 - 2. CONTEMPLATION**
 - 3. PREPARATION**
 - 4. ACTION**
 - 5. RELAPSE**

PRE-CONTEMPLATION

The woman is not considering change during the pre-contemplation stage.

- She may not believe it is necessary (examples: used during last pregnancy and nothing happened, or her mother used while pregnant with her and she is okay).
- She may not know or understand the risks involved.
- She has tried many times to quit without success, so she has given up and doesn't want to try again.
- She has gone through withdrawal before and is fearful of the process or effects on her body.
- She feels strongly that no one should tell her what to do with her body.
- She has mental illness or developmental delay and does not have a good grasp of what using drugs and alcohol during pregnancy means—even when information is given to her.
- She has family members or a partner, whom she depends on, who use. She may not contemplate changing when everyone else continues to use.

The woman in pre-contemplation may present as resistant, reluctant, resigned, or rationalizing.

RESISTANT: “Don’t tell me what to do.”

PROVIDER RESPONSE: Work with the resistance. Avoid confrontation and try to solicit the woman’s view of her situation. Ask her what concerns her about her use and ask permission to share what you know, and then ask her opinion of the information. Accept that this process of change is a gradual one, and it may require several conversations before she feels safe discussing her real fears. This often leads to a reduced level of resistance and allows for a more open dialogue. Try to accept her autonomy but make it clear that you would like to help her quit or reduce her use if she is willing.

RELUCTANT: “I don’t want to change; there are reasons.”

PROVIDER RESPONSE: Empathize with the real or possible results of changing (for example, her partner may leave). It is possible to give strong medical advice to change and still be empathetic to possible negative outcomes to changing. Guide her problem solving.

RESIGNED: “I can’t change; I’ve tried.”

PROVIDER RESPONSE: Instill hope; explore barriers to change.

RATIONALIZING: “I don’t use that much.”

PROVIDER RESPONSE: Decrease discussion. Listen rather than respond to the rationalization. Respond to her by empathizing and reframing her comments to address the conflict of wanting a healthy baby and not knowing whether “using” is really causing harm.

CONTEMPLATION

The woman is ambivalent about changing her behavior. She can think of the positive reasons to change but also is very aware of the negative sides of change (see above).

PROVIDER RESPONSE: Health care providers can share information on the health benefits of changing for the woman and fetus. The woman in contemplation will hear these benefits, but is very aware of the negative aspects of change on her life. Help the woman explore goals for a healthy pregnancy, and problem solve how to deal with the negative aspects of quitting alcohol and drug use and remaining abstinent.

PREPARATION

The woman’s ambivalence is shifting toward changing her behavior. She is exploring options to assist her process. She may be experimenting by cutting down or has been able to quit for one or more days. Although her ambivalence is lessening, it is still present and may increase when she is challenged by those around her, triggered by the environment, or is under other types of stress she has handled by using in the past.

PROVIDER RESPONSE: Acknowledge strengths, anticipate problems and pitfalls to changing, and assist the woman in generating her own plan for obtaining abstinence. Problem solve with her regarding barriers to success. Work on plans for referral to treatment.

ACTION

The woman has stopped using drugs and/or alcohol.

PROVIDER RESPONSE: Acknowledge her success and how she is helping her infant and herself; have her share how she has succeeded and how she is coping with the challenges of not using. Offer to be available for assistance if she feels that she wants to use drugs/alcohol again. Provide assistance with treatment referrals: Discuss triggers and social pressures that may lead to relapse, and help the woman plan for them.

RELAPSE

The woman may relapse; incidence of relapse for those who are abusing or addicted is high.

PROVIDER RESPONSE: If relapse has occurred, guide the woman toward identifying what steps she used to quit before. Offer hope and encouragement, allow the woman to explore the negative side of quitting and what she can do to deal with those issues. (How did she deal with those issues in the past? Explore what worked and what didn’t work for her.) Offer to provide assistance in finding resources to help her return to abstinence.

Laboratory Testing

Urine toxicology determines the presence or absence of a drug in a urine specimen. It may be useful as a follow up to a positive interview screen.

Benefits of Lab Testing

- Confirms the presence of a drug
- Determines the use of multiple drugs
- Determines if a newborn is at risk for withdrawal

Limitations of Lab Testing

- Negative results do not rule out substance use.
- A positive test does not tell how much of a drug is used.
- A positive test does not identify user characteristics such as intermittent use, chronic use, or addiction.
- Alcohol, which is the most widely abused substance and has the greatest impact on the fetus, is the hardest to detect due to its short half-life.
- A woman who knows she will be tested may delay access to prenatal care because she fears potential repercussions.
- False positive results can be devastating for a drug-free client.
- Urine toxicology has no value in identifying or minimizing the teratogenic effects that occur early in pregnancy.
- Blood tests usually only identify those patients with long term use in whom secondary symptoms have occurred, e.g., liver function tests.
- Women may avoid detection by abstaining for 1–3 days prior to testing, substituting urine samples, or increasing oral beverage intake just before the testing to dilute the urine.

Indicators for Testing

Some risk indicators are more predictive of substance use than others. If positive risk indicators are identified at any time during pregnancy or postpartum, rule out other identifiable causes, re-screen, test, or provide assessment as appropriate.

HIGH RISK FACTORS

- Little or no prenatal care
- Inappropriate behavior (e.g., disorientation, somnolence, loose associations, unfocused anger)
- Physical signs of substance abuse or withdrawal
- Smell of alcohol and/or chemicals
- Recent history of substance abuse or treatment

RISK FACTORS REQUIRING FURTHER ASSESSMENT BEFORE URINE TOXICOLOGY TESTING

- History of physical abuse or neglect
- Intimate partner violence
- Mental illness
- Previous child with FAE/S or alcohol-related birth defects
- Fetal distress
- Abruptio placenta
- Preterm labor
- Intrauterine Growth Restriction (IUGR)
- Previous unexplained fetal demise
- Hypertensive episodes
- Stroke or heart attack
- Severe mood swings
- History of repeated spontaneous abortions



BEHAVIOR PATTERNS

- Sedation
- Inebriation
- Euphoria
- Agitation
- Aggression
- Increased physical activity
- Anxiety and nervousness
- Irritability
- Disorientation
- Prescription drug-seeking behavior
- Suicidal ideation/attempt
- Sexual promiscuity
- Dishonesty
- Unreliability

PHYSICAL FINDINGS

- Track marks and other evidence of intravenous drug use
- Alcohol on the breath
- Inflamed/eroded nasal mucosa, nose bleeds
- Scars, injuries
- Hypertension
- Tachycardia or bradycardia
- Tremors
- Slurred speech
- Self-neglect or poor hygiene
- Liver or renal disease
- Runny nose
- Chronic cough
- Cheilosis
- Nervous mannerisms (e.g., frequently licking lips, jitters, foot tapping)
- Pinpoint or dilated pupils
- Rapid eye movements
- Reproductive dysfunction (hypogonadism, irregular menses, miscarriage, infertility, fetal alcohol syndrome)
- Low weight gain
- Poor nutritional status
- Physical abuse
- STDs
- History of low birth weight or preterm delivery

PSYCHOLOGICAL PROBLEMS

- Memory loss
- Depression
- Anxiety
- Panic
- Paranoia
- Unexplained mood swings
- Personality changes
- Intellectual changes

MEDICAL HISTORY

- Frequent hospitalizations
- Gunshot/knife wound
- Unusual infections (cellulitis, endocarditis, atypical pneumonias, HIV)
- Cirrhosis
- Hepatitis
- Pancreatitis
- Diabetes
- Frequent falls/unexplained bruises
- Chronic mental illness

LABORATORY

- MCV over 95
- Elevated MCH, GGT, SGOT, bilirubin, triglycerides
- Anemia
- Positive urine toxicology for drugs
- Testing for sexually transmitted infections (including HIV, hepatitis C)

**Signs and Symptoms of Substance Abuse**

Because of the frequency of complications seen in substance abusers, it is important that the clinician be alert for clinical and historical cues that may indicate the possibility of substance abuse. Based on clinical observation, laboratory testing for substance abuse may be indicated in order to provide information for the health care of the mother and newborn.

Consent Issues for Testing

The importance of clear and honest communication with the woman regarding drug testing cannot be overstated. The healthcare team should act as advocate for mother and infant. This relationship is more difficult to establish if the woman is notified of testing after the fact. All women should be informed of planned medical testing, the nature and purpose of the testing, and how results will guide management.

Assist/Arrange

Referral to Treatment

Discuss the benefits of treatment and offer to provide the woman with a referral to a local substance abuse treatment center. If the woman is unwilling to make that commitment, ask if she would like some information to take with her if she should change her mind. Schedule the next prenatal visits, continue to maintain interest in her progress, and support her efforts in changing. Monitor and follow up on any co-existing psychiatric conditions.

- Know your resources: Maintain a current list of local resources. *See Appendix C for statewide resources.* If possible, make the appointment while the patient is in the office.
- Discuss the possible strategies for her to stop; for example, individual counseling, 12-step programs, and other treatment programs. Studies have shown that people given choices are more successful in treatment.
- It is federally mandated that pregnant women are a priority population for treatment and should be seen by a substance abuse treatment provider within 48 hours.
- Tailor resources according to client needs and health insurance coverage.
- Maintain communication with the substance abuse treatment provider to monitor progress and adherence to treatment.
- Encourage and support any reduction in use. See the section on Harm Reduction.
- For tobacco users, provide the ACOG brief intervention and refer women to the state Vermont Quit Network 1-800-QUIT-NOW (1-800-784-8669) or vtquitnetwork.org.

Harm Reduction

Women with a diagnosis of dependence (addiction) can't control their use. When abstinence is not possible, harm reduction assists a woman to take steps to reduce use and harm to herself and her fetus. Explore if there are ways she can cut down on use and enroll in outpatient treatment or attend recovery meetings to begin to learn more options to reduce use. Opiate withdrawal can cause harm (miscarriage, preterm delivery, and intrauterine demise), and women who experience opiate withdrawal symptoms need medical help. Praise any reduction in use. Though drug/alcohol abstinence is the goal, any steps made toward reducing use and/or harmful consequences related to use are very important.

Harm Reduction Strategies

- Evaluate and refer for underlying problems.
- Encourage the woman to keep track of substance use.
- Recommend reducing dosage and frequency of use.
- Recommend reducing her use by one-half each day; if this is not possible, any decrease in use is beneficial.
- Intersperse use with periods of abstinence.
- Encourage a safer route of drug administration.
- Help her to explore substitutes for the substance.
- Encourage her to avoid drug-using friends.
- Discuss contraceptive methods for after delivery, and make a plan.

Medication-Assisted Treatment (MAT)⁵ of Opiate Dependence

Methadone has been the state of the art for the treatment of opiate dependence. While methadone is associated with public controversy, it is one of the most highly studied medications in the world. It has been shown to be much more effective for the treatment of opiate dependence than abstinence or with the use of an opiate blocker. Methadone may only be used for the treatment of opiate dependence in a certified Opiate Treatment Program or clinic.

The Drug Addiction Treatment Act of 2000 (DATA 2000) outlines a waiver process. For the first time, this allowed physicians to provide in-office treatment of opiate-dependence rather than referring to a methadone clinic.⁶ The only medication approved for this is buprenorphine either as a single agent (Subutex) or a compound that contains both buprenorphine and naloxone (Suboxone).

Treatment Options for Opiate-Addicted Pregnant Women in Vermont

The decision to be on medication or not is a serious one. Generally, MAT is reserved for anyone who has tried to stop using before and has been unsuccessful. If a woman who is on methadone or buprenorphine becomes pregnant, the decision to stop the medication is discouraged. However, in certain cases, it can be allowed, but a taper should ideally occur during the second trimester to minimize any risk to the pregnancy. Again, the benefits of MAT generally outweigh any risks when pregnant, as a return to drug use is not desired. *For details on treatment options and resources see Appendix C.*

⁵ Substance Abuse and Mental Health Administration Medically Assisted Treatment. Available at: <http://csat.samhsa.gov/publications/MedicalCommunity.aspx>.

⁶ TIP 40: Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction. Available at: <http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.chapter.72248>.

TIP 43: Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs. Available at: <http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.chapter.82676>.

Pregnant women in methadone or buprenorphine treatment should be referred to additional support services. These programs should collaborate around her treatment plan to facilitate the best outcomes for the pregnancy.

Suggestions for a Referral Process

The first step in referring a substance-abusing pregnant or mothering woman is to contact your local Vermont Department of Health office. *See Appendix D.* Each public health office will be able to provide you next steps in the referral process in your area.

At the time of the referral

An informing process with the individual occurs at the time of the referral that includes:

- Information sharing and protecting confidentiality.
- Obtaining a signed informed consent to make a referral.
- Discussion of what to expect during the next steps of the referral process.
- Assistance with making the referral and explanation of what the result of the referral will be (i.e., next steps).
 - Identifying the individual's current support person(s).
 - Promoting the individual's role in being an active participant in planning support services that are meaningful to them.
- When they will be contacted (timeliness).
- Who will be contacting them (give agency name and number).
- What will happen (further assessment/evaluation, planning, treatment, counseling, etc.).



Pregnancy Management

A woman who uses substances during pregnancy is at risk for a variety of complications. The following interventions should be considered in the course of her care.

Prenatal

- Obtain routine blood tests plus hepatitis C and tuberculin test and HIV if not included in routine protocol.
- Counsel regarding smoking cessation/reduction.
- Periodically screen for sexually transmitted infection.
- Refer to a substance abuse treatment center for opioid agonist therapy or medical detox if applicable. Medication-assisted therapy for opioid dependence with methadone (medication of choice), or buprenorphine (if no other treatment is available and after informed consent), is recommended during pregnancy. Detoxification, or medically assisted withdrawal, is not recommended during pregnancy due to high relapse rates. It should be strongly discouraged late in pregnancy as in utero fetal withdrawal is a theoretical possibility.
- Coordinate care with the medication-assisted therapy provider, counselor, pediatrics (to plan for neonatal assessment), and nursing services.
- Schedule more frequent visits to identify medical and psychosocial problems early.
- Conduct random urine toxicologies to monitor use and/or how well the woman is doing with treatment. Expect an occasional positive urine tox, and use this as an opportunity to talk about her progress.
- Order and repeat appropriate tests as needed.
- Monitor pregnancy and fetal development. Watch fetal growth, as there is an increased risk of growth restriction.
- Consider anesthesia or pain management consultation prior to delivery to develop a pain management plan, especially if cesarean delivery is planned.
- Discuss contraceptive methods and make a plan.
- Discuss possible effects of drugs on the newborn.
- Obtain consent for tubal ligation after delivery if the woman chooses this method.
- Discuss breastfeeding and alcohol/drug use issues.

Intrapartum

- Perform complete history and physical, including recent drug use.
- Repeat hepatitis screen, serologic test for syphilis, and HIV.
- Repeat urine toxicology.
- Alert pediatric and nursing staff.
- Alert social services if necessary.
- Determine method of delivery depending on obstetrical indicators.

- Take into consideration the woman's substance abuse history and recovery status with respect to pain management. Adequate pain management should be available to all laboring mothers who desire it. A substance abuse history should not be considered a contraindication to the normal use of pain medications in labor.
- Short acting opioid analgesic medications can be prescribed while maintaining medication assisted therapy.
- Partial opioid agonists, such as nalbuphine or butorphanol, are contraindicated and can precipitate withdrawal and non-reassuring fetal status.
- Epidural anesthesia can be used as per hospital routine and is a proven effective pain management strategy for laboring women.
- Following vaginal birth, standard pain medications should be made available.
- Following cesarean birth, short-acting opioid analgesic medications should be prescribed in addition to opioid maintenance therapy (which does not provide analgesia). Patient-controlled analgesia or patient-controlled epidural analgesia can be used. Short-acting opioid analgesic dose may need to be increased by approximately 50% (or more potent opioid chosen). The increase is similar in women maintained on either methadone or buprenorphine.
- Consult with the pain-management service for intractable pain.
- Avoiding sedatives such as benzodiazepines and Ambien, Sonata, Lunesta, etc. is advised. This will decrease the risk of respiratory suppression in a patient receiving high doses of opiates. Sedatives have also been associated with relapse to substance abuse.
- Benzodiazepines can cause respiratory depression and should not be used.

Postpartum

- Encourage continuation in a therapeutic drug program.
- Encourage and provide appropriate contraceptive method: Depo-Provera, IUD, ECP (Emergency Contraceptive Pills), condoms, others. These medications are compatible with medication-assisted therapy.
- Support breastfeeding as appropriate. Breastfeeding is not contraindicated in methadone maintenance, depending on the dose, but is contraindicated if the woman is HIV positive. It is generally recommended that women receiving buprenorphine breast feed, although there is not yet sufficient data to support this recommendation.

Associated Issues for Pregnant Women

Pregnant women who need treatment for substance abuse often have different issues than men and non-pregnant women. Pregnancy further complicates treatment needs. Issues of pregnant women may include:

PSYCHOSOCIAL ISSUES

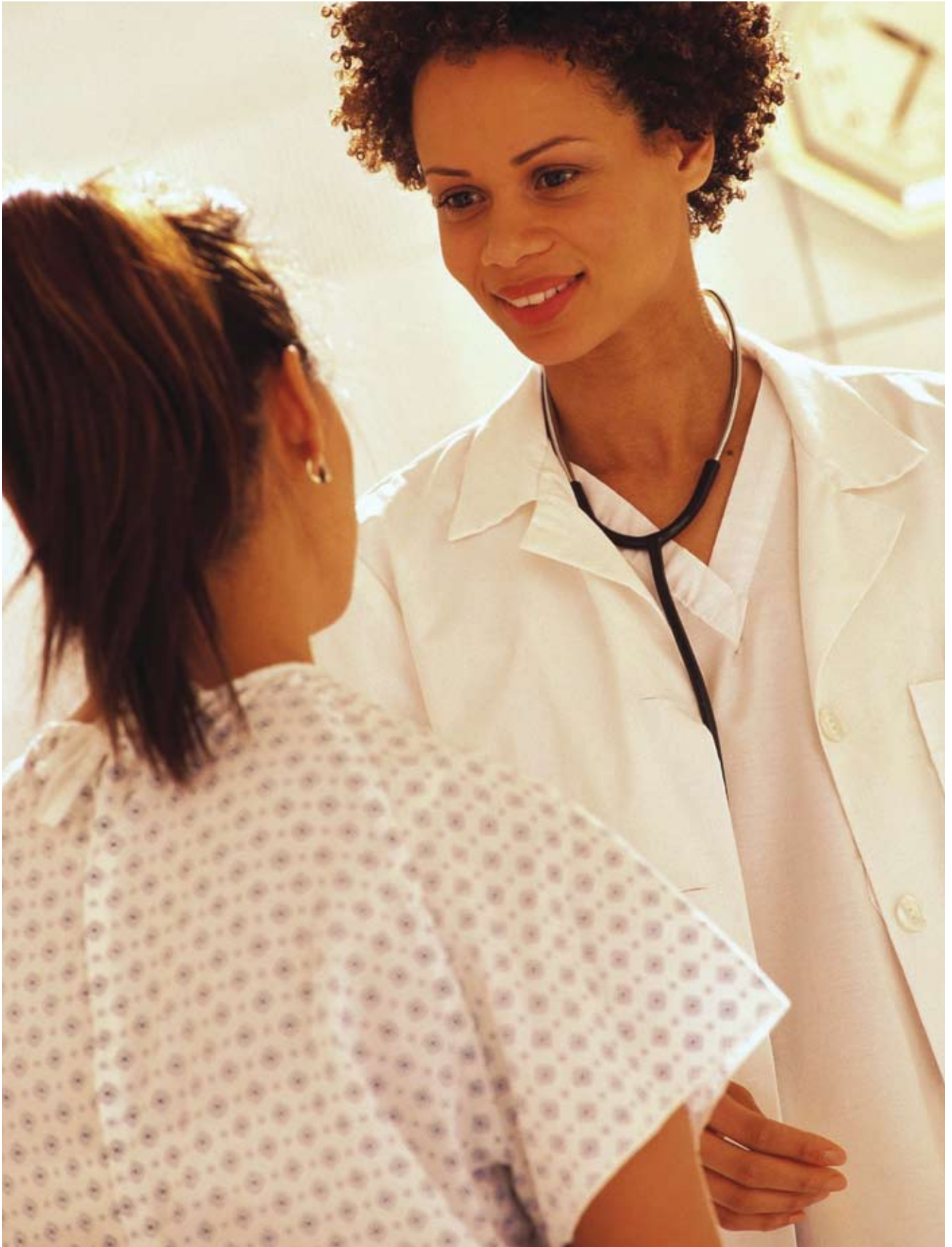
- Family history of substance abuse
- Physical and/or sexual abuse as a child
- History of sexual assault
- Domestic violence
- Partner with substance abuse issues
- Cultural barriers to care
- Unresolved childhood parenting issues such as substance use, incarceration, and dysfunctional family relationships

MEDICAL ISSUES

- Sexually Transmitted Infections (STI)
- HIV
- Poor nutrition
- Psychological disorders such as PTSD (post traumatic stress disorder), depression, anxiety, panic, personality disorders, eating disorders, chronic severe mental illness
- Other medical problems such as hepatitis, liver disease, and pancreatitis
- Tobacco use
- Dental disease
- Unintended pregnancy
- Breastfeeding challenges and barriers

POTENTIAL REFERRALS

- Childbirth preparation class
- Transportation services
- Public assistance/medical assistance/food stamps
- WIC Nutrition Program
- Child care (day care, foster care)
- Support groups
- Parent skill-building services
- Education and career-building support
- Safe and sober housing access
- Legal services
- Child Protective Services
- Adoption counseling
- Pediatric follow-up care for infant
- Mental health services
- Domestic violence counseling and services
- Infant development follow-up services

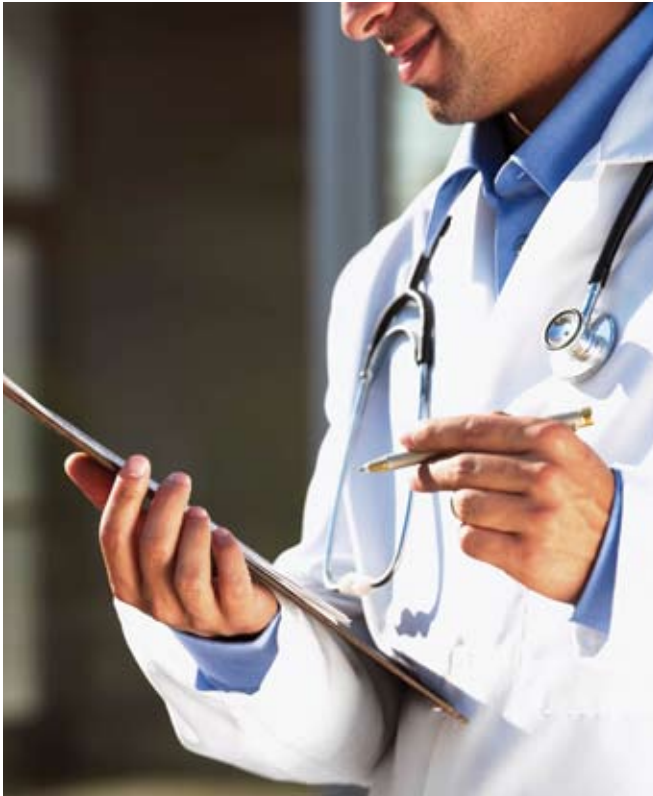


Newborn Concerns

It is not necessary to test a newborn with signs of drug withdrawal whose mother has a positive drug test or a reliable drug history. This newborn may be presumed drug exposed.

Newborn characteristics that may be associated with maternal drug use (ACOG 2004) are as follows.

- Jittery with normal glucose level
- Marked irritability
- Preterm birth
- Unexplained seizures or apneic spells
- Unexplained IUGR
- Neurobehavioral abnormalities
- Congenital abnormalities
- Atypical vascular incidents
- Necrotizing enterocolitis in otherwise healthy term infants
- Signs of neonatal abstinence: marked irritability, high pitched cry, feeding disorders, excessive sucking, vomiting, diarrhea, rhinorrhea, and diaphoresis (Finnegan, 1986). Neonatal signs of opiod dependence may be delayed for as long as 10–14 days depending on the life of the substance in question but are most likely to present in the first four days of life.



Issues of Testing

VDH and AHS cannot provide legal counsel on this topic, but the following key points should be considered.

- Each hospital with perinatal/neonatal services should work with hospital risk management, nursing services, social services, medical staff, and local DCF to develop a defined policy for identifying intrapartum women and newborns with substance use/abuse. This hospital policy should be written in collaboration with local DCF guidelines and include consent and reporting issues.
- Newborn drug testing is done for the purposes of determining appropriate medical treatment. There is no recommendation to test newborns whose mothers are compliant with a substance abuse treatment program.
- It may be helpful to test the newborn if there is suspected history of substance abuse, or the mother is not compliant with her treatment program.
- Reporting toxicology screens to DCF does not represent an allegation of abuse or neglect. The health care team acts as an advocate for mother and newborn. For Vermont DCF policy on substance abuse and families, visit http://dcf.vermont.gov/sites/dcf/files/pdf/fsd/policies/52A_Family_Assessments_interim_7-1-09__4_.pdf.
- All women should be informed about planned medical testing, nature and purpose of testing, and how results will guide management. This should include the benefits of and/or consequences of the test. Drug testing is based on specific criteria and medical indicators not open-ended criteria such as “clinical suspicion” that invites discriminatory testing.
- If a woman refuses testing, maternal testing should not be performed. However, testing of the newborn may still occur if medically necessary. It is strongly encouraged that each institution develop justification and process for newborn testing.

About Newborn Toxicology

A detailed, professionally obtained history is more helpful than toxicology screening of the newborn to accurately screen for substance abuse.

Correlation between maternal and newborn test results is poor, depending upon the time interval between maternal use and birth, properties of placental transfer, and time elapsed between birth and neonatal urine collection.

The earliest urine of the newborn will contain the highest concentration of substance. Newborn urine reflects exposure during the preceding 1–3 days. Cocaine metabolites may be present for 4–5 days, and marijuana may be detected in urine for weeks depending on maternal usage. Alcohol is nearly impossible to detect in newborn urine.

Other methods of newborn testing include meconium. Meconium in infants reflects substance exposure during the second half of gestation. Preterm infants may not be good candidates for meconium testing. Consider that intrapartum drugs prescribed to control labor pain may be detected in meconium.

Management of a Drug-Exposed Newborn

Use a neonatal abstinence scoring tool to document symptoms of opioid withdrawal. *See Appendix E for modified Finnegan scoring tool and guide to use of the tool.*

Newborn assessment should include newborn health status, maternal drug use or history, and current family situation. Document assessment of family interactions, including positive observations as well as areas of concern. Social work staff may be included to coordinate any referrals that are needed.

Neonatal Abstinence Syndrome (NAS)

Neonatal abstinence syndrome is a generalized disorder characterized by signs and symptoms of central nervous system irritability, gastrointestinal dysfunction, mild respiratory distress, and nonspecific autonomic symptoms such as yawning and sneezing, mottled color, and fever.

NAS is generally seen in infants exposed to opioids. It is also described in those with other drug and tobacco exposures.

Approximately 50–75% of infants born to women on methadone require medication for withdrawal symptoms. Preliminary data suggests that buprenorphine during pregnancy may result in a lower incidence and severity of neonatal withdrawal symptoms. The maternal dose of methadone is not related to the incidence or severity of neonatal withdrawal symptoms. Signs and symptoms generally occur within 96 hours of life.

Signs and symptoms of drug withdrawal in the newborn are not specific and other causes should be considered. Neonatal sepsis, hypoglycemia, and neurological conditions can result in a similar clinical presentation.

Neonatal Abstinence Scoring

- The Modified Finnegan Neonatal Abstinence Scoring Tool is used to assist in assessment of withdrawal symptoms.
- Elevated NAS scores should not be used for diagnosis of NAS in the absence of a supporting history of substance use or medication-assisted treatment during pregnancy.
- In newborns with in utero exposure to opioids, the first assessment is done at 2 hours of age and then every 3–4 hours before feedings.
- *Refer to Appendix E for NAS scoring tool and guidelines for use.*

General Management

- Infants should remain in the hospital for a minimum of 96 hours to assess withdrawal symptoms.
- Women who are new to substance abuse treatment or who are not stable in their recovery should meet with a social worker for assistance with referrals and/or to reconnect with prenatal supports.
- The social worker should make an assessment about a safe and appropriate discharge.

Support for Managing NAS

- Initial management consists of providing a supportive/calming environment.
- Specialized handling may reduce abstinence scores.
- Pacifiers are recommended to aid in calming infants.
- Pharmacologic therapy is indicated for infants who have persistently high NAS scores despite optimizing supportive care.

Breast Feeding

- Breast feeding is recommended for all infants unless the mother is HIV positive.
- Maternal hepatitis B and C are not contraindications to breast feeding.
- Women on methadone maintenance should be encouraged to breast feed; only small amounts are transmitted through breast milk.
- It is generally recommended that women receiving buprenorphine breast feed, although there is not yet sufficient data to support this recommendation.

Infants Born to Women Positive for Hepatitis C Antibody

- The rate of mother-to-infant hepatitis C viral transmission is in the range of 1.0%–5.0%.
- Infants born to infected mothers should be tested for hepatitis C antibody at 18 months of age.
- If a diagnosis is needed sooner than 18 months of age:
 - Obtain a quantitative PCR at 2 & 4 months of age (must have 2 results).
 - Hepatitis C antibody lab test at 18 months of age.

Appendices

- 19 **APPENDIX A** Screening Tools for Drugs, Alcohol, and Tobacco
- 23 **APPENDIX B** Intimate Partner Violence Screening Tool
- 24 **APPENDIX C** Treatment Options and Resources for Opiate-Dependent Pregnant Women in Vermont
- 26 **APPENDIX D** Vermont Resources and Offices of Local Departments of Health (VDH)
- 27 **APPENDIX E** Neonatal Abstinence Syndrome (NAS) Scoring Sheet and Guidelines



Appendix A

Screening Tools for Drugs, Alcohol, and Tobacco

CAGE

- C** Have you ever felt you ought to **cut down** on your drinking or drug use?
- A** Have people **annoyed** you by criticizing your drinking or drug use?
- G** Have you ever felt bad or **guilty** about your drinking or drug use?
- E Eye-opener:** Have you ever had a drink or drug first thing in the morning to steady your nerves or get rid of a hangover?

The CAGE can identify alcohol problems over the lifetime. Two positive responses are considered a positive test and indicate further assessment is warranted.

National Institute on Alcohol Abuse and Alcoholism

4 P's

This screening device is often used as a way to begin discussion about drug or alcohol use. Any woman who answers yes to one or more questions should be referred for further assessment.

1. Have you ever used drugs or alcohol during this **pregnancy**?
2. Have you had a problem with drugs or alcohol in the **past**?
3. Does your **partner** have a problem with drugs or alcohol?
4. Do you consider one of your **parents** to be an addict or alcoholic?

Ewing H, Born Free Project, Martinez, California

T-ACE

A score of 2 or more is considered positive. Affirmative answers to questions A, C, or E = 1 point each. Reporting tolerance to more than two drinks (the T question) = 2 points.

- T Tolerance:** How many drinks does it take to make you feel high?
- A** Have people **annoyed** you by criticizing your drinking or drug use?
- C** Have you ever felt you ought to **cut down** on your drinking or drug use?
- E Eye-opener:** Have you ever had a drink or drug first thing in the morning to steady your nerves or get rid of a hangover?

Sockol RJ, et al. (1989) The T-ACE questions: Practical prenatal detection of risk drinking. AM Journal of Obstetrics and Gynecology. 160(4).

Chang G. (2001) Alcohol-Screening Instruments for Pregnant Women. Alcohol Research and Health, 25 (3), 204–209.

Smoking Cessation Intervention for Pregnant Patients

Ask

(1 minute)

Ask the patient to choose the statement that best describes her smoking status:

- A. I have NEVER smoked or have smoked LESS THAN 100 cigarettes in my lifetime.
- B. I stopped smoking BEFORE I found out I was pregnant, and I am not smoking now.
- C. I stopped smoking AFTER I found out I was pregnant, and I am not smoking now.
- D. I smoke some now, but I have cut down on the number of cigarettes I smoke SINCE I found out I was pregnant.
- E. I smoke regularly now, about the same as BEFORE I found out I was pregnant.

If the patient stopped smoking before or after she found out she was pregnant (B or C), reinforce her decision to quit, congratulate her on success in quitting, and encourage her to stay smoke free throughout pregnancy and postpartum.

If the patient is still smoking (D or E), document smoking status in her medical record, and proceed to **ADVISE**, **ASSESS**, **ASSIST**, and **ARRANGE**.

Advise

(1 minute)

Provide clear, strong advice to quit with personalized messages about the benefits of quitting and the impact of smoking and quitting on the woman and fetus.

Assess

(1 minute)

Assess the willingness of the patient to attempt to quit within 30 days.

If the patient is willing to quit, proceed to **ASSIST**. If the patient is not ready, provide information to motivate the patient to quit and proceed to **ARRANGE**.

Assist

(3 minutes+)

Suggest and encourage the use of problem-solving methods and skills for smoking cessation.
(e.g., identify “trigger” situations)

Provide social support as part of the treatment.
(e.g., “we can help you quit”)

Arrange social support in the smoker’s environment.
(e.g., identify “quit buddy” and smoke-free space)

Provide pregnancy-specific, self-help smoking cessation materials.

Arrange

(1 minute+)

Assess smoking status at subsequent prenatal visits and, if patient continues to smoke, encourage cessation.

CAGE

- C** Have you ever felt you ought to **cut down** on your drinking or drug use?
- A** Have people **annoyed** you by criticizing your drinking or drug use?
- G** Have you ever felt bad or **guilty** about your drinking or drug use?
- E** **Eye-opener**: Have you ever had a drink or drug first thing in the morning to steady your nerves or get rid of a hangover?

The CAGE can identify alcohol problems over the lifetime. Two positive responses are considered a positive test and indicate further assessment is warranted.

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This screening device is often used as a way to begin discussion about drug or alcohol use. Any woman who answers yes to one or more questions should be referred for further assessment.

1. Have you ever used drugs or alcohol during this **pregnancy**?
2. Have you had a problem with drugs or alcohol in the **past**?
3. Does your **partner** have a problem with drugs or alcohol?
4. Do you consider one of your **parents** to be an addict or alcoholic?

Ewing H, Born Free Project, Martinez, California



Appendix B

Intimate Partner Violence Screening Tool

The goal of routine screening for domestic violence is to both validate the patient's experiences and provide her with support and information about options she has and resources that are available to her.

It Is Important to:

- Ask all patients.
- Ask patients in a confidential setting and not in the presence of their partner.
- Use a non-judging tone.
- Ask direct or indirect questions.
- Be prepared to offer support and information if she answers in the affirmative.
- Be prepared to share the statewide Domestic Violence Hotline number by having cards on hand that you can either give out, or she can take as she wishes.

Normalize the Issue by Framing the Question

- Violence can be a problem in many people's lives, so I now ask every patient I see about domestic violence.
- Many patients I see are coping with an abusive relationship, so I've started asking about domestic violence routinely.

Direct Questions

- At any time has a partner hit, kicked, or otherwise hurt or frightened you?
- Has your partner or ex-partner ever hit or hurt you? Has he/she ever threatened to hurt you?

Indirect Questions

- Every couple has conflicts. What happens when you and your partner have a disagreement? Do conflicts ever turn into physical fights?
- I see patients in my practice who are being hurt or threatened by someone they love. Is this happening to you?
- Do you ever feel afraid of your partner?

If You Get a "Yes," Ask:

- Are you in danger now?
- Do you want me to help you to call the police?
- Do you want to speak to an advocate from a domestic violence program in our community?
- Can I give you Vermont's 24-hour Domestic Violence Hotline number?

Remember that your goal is to validate her experiences and offer information. Keep in mind that convincing her to leave or helping her to figure out a way to "fix" her relationship or to get her abuser to change is not the goal of routine screening.

Use compassionate and supportive language, especially if you suspect abuse and she denies its presence.

If, as a medical practitioner, you feel at a loss or unsure, you can also call the 24-hour hotlines to get more information.

Domestic Violence Hotline..... 1-800-228-7395
Sexual Violence Hotline..... 1-800-489-7273

Appendix C

Treatment Options and Resources for Opiate-Dependent Pregnant Women in Vermont

Options for opiate addiction may be determined in part by what treatment resources and prenatal care are available in the geographic area in which the pregnant woman lives. The following types of treatment are listed in ascending order of intensity and are based on the well established American Society of Addiction Medicine (ASAM) Patient Placement Criteria. Those treatments that use medications are known as Medication-Assisted Treatment (MAT). *Resource contact information is available in Appendix D.*

1. Early Intervention

Appropriate for women with a very short period of drug use.

2. Outpatient Treatment without Medication

Appropriate for women at minimal risk of withdrawal from opiates, who demonstrate motivation for treatment.

Resource: Outpatient Substance Abuse Treatment Program available in your area.

3. Intensive Outpatient

Appropriate for women at minimal risk of withdrawal from opiates, based on level of use, with corresponding emotional or behavioral complications of mild severity.

4. Outpatient Opiate Treatment or Office-Based Opiate Treatment (OBOT)

Appropriate for opiate users at risk for withdrawal. Buprenorphine is an opiate substitute that can only be prescribed from an office-based setting by a medical doctor with special training. Counseling is a very important part of this treatment. Although short term maternal and neonatal outcomes are favorable, buprenorphine has not been approved by the FDA for use in pregnancy.

5. Opiate Treatment Program (OTP)

Appropriate for the highest risk patients who can be treated in outpatient settings. This is an intensive outpatient program than uses methadone for treatment. Methadone is considered the medication of choice for treatment of opiate dependency in pregnancy. *There is no waiting list in Vermont at any of these clinics for a pregnant woman who is opiate addicted.*

6. Medically Monitored Intensive Inpatient

Appropriate for women at risk for withdrawal from opiates or other substances, with concurrent emotional or behavioral complications of moderate to high severity.

7. Medically Managed Intensive Inpatient

Appropriate for women who are at the highest risk for withdrawal from opiates and/or other substances. This would involve admission to the obstetrical unit with evaluation, observation, and initiation of methadone or buprenorphine treatment, if indicated. It would include a full obstetrical evaluation, consultation with addiction specialists, neonatal specialists, and other medical and psychiatric providers if necessary. Referral to a methadone clinic, other inpatient venues, or a buprenorphine provider would occur based on the medical team's consensus. Often, follow-up can occur at the outpatient obstetrical clinic on a regular basis.

VDH-Approved Substance Abuse Treatment Providers*

Addison

Counseling Service of Addison
County (A, I, O, PC)
89 Main Street
Middlebury, VT 05753
802-388-6751 Tel
802-388-3108 Fax

HowardCenter Centerpoint
Adolescent Treatment Services
(A, I, O)
1025 Airport Drive
South Burlington, VT 05403
802-488-7711 Tel
802-488-7732 Fax

Bennington

United Counseling Services
(A, O, PC, PIP)
100 Ledge Hill Drive
P.O. Box 588
Bennington, VT 05201
802-442-5491 Tel
802-442-1707 Fax

HowardCenter
The Chittenden Clinic (M)
c/o University Health Care
1 South Prospect Street, Room 1420
Burlington, VT 05401
802-656-3700 Tel
802-488-6450 Fax

Northshire UCS (O)
5312 Main Street, P.O. Box 815
Stephen C. Lundy Building
Manchester Center, VT 05255
802-362-3950 Tel
802-362-0325 Fax

Day One (I)
UHC Campus
3rd floor, St. Joseph's
1 South Prospect Street
Burlington, VT 05401
802-847-3333 Tel
802-847-3326 Fax

Chittenden

HowardCenter
(A, O, PC)
855 Pine Street
Burlington, VT 05401
802-488-6100 Tel
802-488-6102 Fax

Lund Family Center
Cornerstone Drug Treatment
Program (A, O, W)
76 Glen Road, P.O. Box 4009
Burlington, VT 05406
802-864-7467 Tel
800-639-1741 Toll-free
802-864-1619 Fax

HowardCenter
Act 1/Bridge Program (PIP, R)
184 Pearl Street
Burlington, VT 05401
802-488-6425 Tel
802-488-6431 Fax

Maple Leaf Farm (R)
10 Maple Leaf Road
Underhill, VT 05489
802-899-2911 Tel
800-254-5659 Toll-free
802-899-2327 Fax

Spectrum Youth & Family Services (A, O)
177 Pearl Street
Burlington, VT 05401
802-862-5396 Tel
802-660-0578 Fax

Franklin/Grand Isle

HowardCenter (O, PC, PIP)
172 Fairfield Street
St. Albans, VT 05478
802-524-7265 Tel
802-524-5723 Fax

Lamoille

Behavioral Health and Wellness Center (A, O, PC)
530 Washington Highway, Suite 10
Morrisville, VT 05661
802-888-8320 Tel
802-888-8136 Fax

Orange

Clara Martin Center (A, O, PC)
11 North Main Street, P.O. Box G
Randolph, VT 05060
802-728-4466 Tel
802-728-4197 Fax

Clara Martin Center (A, O, PC)
1483 Lower Plain Road,
P.O. Box 278
Bradford, VT 05033
802-222-4477 Tel
802-222-3242 Fax

Valley Vista (R, W, A)
23 Upper Plain
Bradford, VT 05033
802-222-5201 Tel
802-222-5901 Fax

Orleans/Essex/Caledonia

BAART Behavioral Health Services (M)
475 Union Street
Newport, VT 05855-5499
802-334-0110 Tel
802-334-7280 Fax

BAART Behavioral Health Services (M)
445 Portland Street
St. Johnsbury, VT 05819
802-748-6166 Tel
802-748-3316 Fax

Tri-County Substance Abuse Services (A, I, O, PC)
2225 Portland Street, P.O. Box 368
St. Johnsbury, VT 05819
802-748-1682 Tel
802-748-0211 Fax

Tri-County Substance Abuse Services (A, I, O, PC)
154 Duchess Avenue, P.O. Box 724
Newport, VT 05855
802-334-5246 Tel
802-334-1093 Fax

Rutland

Evergreen Services (I, O, PC)
135 Granger Street
Rutland, VT 05701
802-747-3588 Tel
802-775-7196 Fax

Rutland Mental Health Court Square (A, I, O)
7 Court Square
Rutland, VT 05701
802-775-4388 Tel
802-775-3307 Fax

Recovery House Inc.
Serenity House (R)
98 Church Street, P.O. Box 207
Wallingford, VT 05773
802-446-2640 Tel
802-446-2636 Fax

Washington

BAART Behavioral Health Services (M)
300 Granger Road
Berlin, VT 05641
802-223-2003 Tel
802-223-2235 Fax

Central Vermont Substance Abuse Services (A, I, O, PC, B)
100 Hospitality Drive
Berlin, VT 05641
P.O. Box 1468
Montpelier, VT 05601
802-223-4156 Tel
802-223-4332 Fax

Washington County Youth Service Bureau (A, O)
38 Elm Street
Montpelier, VT 05602
P.O. Box 627
Montpelier, VT 05601
802-229-9151 Tel
802-229-2508 Fax

Windham

Health Care & Rehabilitation Services of Southeastern Vermont (A, I, O, PC)
51 Fairview Street
Brattleboro, VT 05301
802-254-6028 Tel
800-622-4235 Crisis
802-254-7501 Fax

Phoenix House
Rise Program I (H)
435 Western Avenue
Brattleboro, VT 05301-6268
802-257-5654 Tel
802-257-7163 Fax

Phoenix House
Rise Program II (H)
11 Underhill Avenue
Bellows Falls, VT 05101
802-463-9851 Tel
802-463-9814 Fax

Phoenix House
Rise Program III (H, W)
178 Linden Street
Brattleboro, VT 05301
802-257-2415 Tel

Starting Now (I)
1 Anna Marsh Lane, P.O. Box 803
Brattleboro, VT 05302
802-258-3707 Tel
802-258-3788 Fax

Habit OpCo (M)
16 Town Crier Drive, P.O. Box 8417
Brattleboro, VT 05304
802-258-4623 Tel
802-258-4629 Fax

Windsor

Health Care & Rehabilitation Services of Southeastern Vermont (A, O, PC)
390 River Street
Springfield, VT 05156
802-886-4567 Tel
800-622-4235 Crisis
802-886-4560 Fax

Health Care & Rehabilitation Services of Southeastern Vermont (A, I, O, PC)
49 School Street, P.O. Box 709
Hartford, VT 05047
802-295-3032 Tel
800-622-4235 Crisis
802-295-0821 Fax

Clara Martin Center
Quitting Time (I)
39 Fogg Farm Road, P.O. Box 816
Wilder, VT 05088
802-295-1311 Tel
802-295-1312 Fax

Out-of-State Resources

Habit OpCo (M)
8 Interchange Drive
West Lebanon, NH 03784
603-298-2146 Tel
603-298-2149 Fax

Phoenix House, Dublin Center (O, R)
3 Pierce Road
Dublin, NH 03444
603-563-8501 Tel
603-563-8296 Fax

Additional Resources

Individual Practitioners: Persons who are licensed or certified and specializing in substance abuse treatment can be found in your local phone book under "Counseling, Alcoholism or Drug Abuse."

Clinical Research Projects (A, O)
(The University of Vermont offers substance abuse treatment as part of clinical research studies.)
802-656-5051

KEY TO SUBSTANCE ABUSE SERVICES AVAILABLE

- (A) Adolescents Program
- (B) Buprenorphine hub
- (H) Halfway house
- (I) Intensive outpatient program
- (M) Methadone program
- (O) Outpatient program
- (PC) Project CRASH (Drinking Driver Program)
- (PIP) Public Inebriate Program
- (R) Residential program
- (W) Women only

These programs may also offer educational materials and presentations, crisis services, or Employee Assistance Programs.

Appendix D

Vermont Resources and Offices of Local Departments of Health (VDH)

Vermont 211

Vermont 211 provides all people in Vermont with free access to community resources through information and referral. This access includes personal assistance by telephone and on line through a searchable database including: child care resource and referral, crisis services, domestic and sexual violence services, education services, health services, legal assistance, alcohol and drug resources, parenting programs, support groups, utility assistance, and much more.

AA Alcohol/Drug Hotline

24-hour addiction helpline and treatment800-257-1975

Crisis Services

Adult Crisis Hotline.....802-860-2400
First Call (children and families)802-864-7777
Domestic Violence Hotline.....800-228-7395
Sexual Violence Hotline.....800-489-7273

Vermont Quit Network800-QUIT-NOW

Vermont Department of Health Offices

The main office for the Vermont Department of Health, Maternal Child Health Programs and the Alcohol and Drug Abuse Programs are located at 108 Cherry Street in Burlington, VT.

The Department of Health operates 12 District Offices located throughout the state. All Vermont residents have a local health office they can count on for health information, WIC services, disease prevention, and emergency response services.

Vermonters depend on their District Offices to promote and protect health through planned programs and activities and to respond to public health threats and emergencies. Most Health Department programs reach the people of Vermont through the District Offices.

The Rocking Horse Circle of Support Program is a ten session educational support group for pregnant and/or parenting women ages 18–40. The groups are free, community based, and lower access obstacles by providing childcare and transportation. Incentives are offered to mothers for attending. The group leaders, a Substance Abuse Specialist and a Maternal Child Health professional offer mothers a unique shared expertise. The groups also provide the attending children structured play where pro-social skills are emphasized. This group intervention is not treatment but may serve as a bridge into the treatment network if needed. The group referrals come from a variety of providers that suspect substance abuse risk in the women they serve and are using the Rocking Horse Program as a care continuum step in addressing this risk. To learn more about a group in your area please contact Patty Baroudi, VT Department of Health, 802-651-1559 or pbaroudi@vdh.state.vt.us.

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20 Houghton Street, Suite 312
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100 Mineral Street, Suite 104
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888-296-8151 Toll-free in VT
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226 Holiday Drive, Suite 22
White River Junction, VT 05001
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Appendix E

Nursing Assessment: Neonatal Abstinence Syndrome Scoring Sheet

MRN	NAME	DOB								
SIGNS AND SYMPTOMS Observations from past 3–4 hours. Start new scoring sheet each calendar day.		Birth Weight: _____ grams (x 90% = _____ grams) Daily Weight: _____ grams								
DATE:	SCORE	TIME	TIME	TIME	TIME	TIME	TIME	TIME	TIME	TIME
High pitched cry: inconsolable >15 sec. OR intermittently for <5 min.	2									
High pitched cry: inconsolable >15 sec. AND intermittently for ≥5 min.	3									
Sleeps <1 hour after feeding	3									
Sleeps <2 hours after feeding	2									
Sleeps <3 hours after feeding	1									
Hyperactive Moro	1									
Markedly hyperactive Moro	2									
Mild tremors: disturbed	1									
Moderate–severe tremors: disturbed	2									
Mild tremors: undisturbed	1									
Moderate–severe tremors: undisturbed	2									
Increased muscle tone	1–2									
Excoriation (indicate specific area): _____	1–2									
Generalized seizure	8									
Fever ≥37.2°C (99°F)	1									
Frequent yawning (≥4 in an interval)	1									
Sweating	1									
Nasal stuffiness	1									
Sneezing (≥4 in an interval)	1									
Tachypnea (rate >60/min.)	2									
Poor feeding	2									
Vomiting (or regurgitation)	2									
Loose stools	2									
≤90% of birth weight	2									
Excessive irritability	1–3									
Total score										
Initials of scorer										
Printed Name	Signature/Title	Initials	Printed Name	Signature/Title	Initials					

Revised Finnegan Score, 2009

NEONATAL ABSTINENCE SYNDROME SCORING AND TREATMENT GUIDELINES: HOSPITALIZED INFANTS

1. Neonatal Abstinence Syndrome (NAS) Scoring

- NAS score at 2 hours of age and every 3 to 4 hours thereafter; continue scoring for the duration of hospitalization (minimum of 96 hours). You may need to wake the infant if necessary.
- Initial treatment consists of providing a supportive environment and non-pharmacological treatment (decrease sensory stimulation, skin to skin, positioning, swaddling, pacifier).
- Score infant before feeding.
- NAS score <9, continue NAS scoring.

- NAS score >12, discuss with attending physician and consider treatment.
- NAS score 9–12, repeat the score (after feeding), within the hour.
 - NAS score <9, continue NAS scoring.
 - NAS score ≥9, discuss with attending physician and consider treatment.

2. Treatment

- If infant has 2 consecutive scores (e.g., before and after feed) of ≥9, consider treatment. Continue to provide a supportive environment (decrease sensory stimulation, positioning, swaddling, pacifier).

Neonatal Abstinence Syndrome (NAS)

Scoring Explanation Reference for the Revised Finnegan Score

ASSESSMENT & DOCUMENTATION

- The hospitalized infant will be assessed every 4 hours and twice a day (8 hours apart) when discharged.
- The NAS score will be recorded for the 4 hour period immediately before the scoring activity.
- Signs and symptoms are documented on the NAS form and totaled for a score.

SYMPTOM RULE OUT

Signs including fever, tachypnea, respiratory distress, or seizures could be due to sepsis or other underlying disease. These suspicions should be excluded first with appropriate tests before they are accepted as part of drug withdrawal.

Sleeping

Use the longest single continuous time sleeping since last feeding.

- Scoring: 0 = Sleeps 3 or more hours continuously.
1 = Sleeps 2–3 hours after feeding.
2 = Sleeps 1–2 hours after feeding.
3 = Sleeps less than 1 hour after feeding.

When repeating a score within 1 hr pc: use the same sleep score obtained ac. Score for feeding based on how the infant just fed.

MORO REFLEX: MOST COMMON METHOD

- Cup infant's head in your hand and raise his/her head about 2–3 inches above the mattress, then drop your hand while holding the infant.
- The infant should be quieted if irritability or crying is present. This will insure that the jitteriness, if present, is due to withdrawal rather than agitation.

MORO REFLEX: OBSERVATION

- Arms straighten, and elbows will move away from the body.
- Extension of the wrists and fanning (opening) of the fingers.
- When the fingers are extended, the infant's index finger and thumb will form a "C" shape.
- This is followed by return of the arms to the chest in a position of passive flexion. The arms may begin to cross over each other.

Hyperactive Moro Reflex

- Scoring: 1 =
- Arms stay up 3–4 seconds.
 - Pronounced jitteriness of the hands during or at the end of a Moro reflex (jitteriness is defined as rhythmic tremors that are symmetrical and involuntary).

Markedly Hyperactive Moro Reflex

- Scoring: 2 =
- Arms stay up more than 4 seconds.
 - Clonus (defined as repetitive jerks [out-in movements of beats] of the wrist or ankle that are involuntary) is present.
 - Elicited by dorsiflexion, hand or foot will slap back on examiner.

TREMORS

Tremors = jitteriness.

- Involuntary movements or quivers that are rhythmical with equal amplitude or strength that occur at a fixed point; for example, quivers of the hand when the wrist is stationary.
- NORMAL: If the infant is asleep, a few jerking movements of the extremities may be present.

Tremors

- Scoring: 1 = Mild tremors. Hands or feet only.
Lasts up to 3 seconds.
2 = Moderate–severe tremors. Arms or legs.
Lasts for more than 3 seconds.
Undisturbed is elicited without touch or manipulation.

INCREASED MUSCLE TONE: METHOD FOR ASSESSMENT

- While the infant is lying supine, passively extend and release the infant's arms and legs to observe for recoil OR...
- Infant supine, grasp arms by wrists and gently lift infant, looking for the head to move after the body (head lag).

Increased Muscle Tone

- Scoring: 0 = Some resistance to extension should be present, but slight extension is possible, and recoil of the extremity will occur spontaneously.
1 = Difficult to straighten arms but is possible, but head lag is present.
2 = No head lag noted, or arms or legs won't straighten.

Excoriation

Excoriation may be the result of constant rubbing of an extremity against a flat surface that is covered with fabric such as bed linen or on the chin from rooting.

- Scoring: 1 = If skin is red but intact or is healing and no longer broken.
2 = If skin breakdown is present.

Convulsions/Seizures

- Scoring: 8 = If any observation of seizure activity.

Fever

- Scoring: 1 = If fever is $\geq 37.2^{\circ}\text{C}$.

Frequent Yawning

Scoring: 1 = If the infant yawns 4 or more times within the 3–4 hour interval.

Sweating

Scoring: 1 = If wetness is felt on the infant's forehead, upper lip.

Sweating on the back of the neck may be from overheating as a result of nursing measures such as swaddling.

Nasal Stuffiness

- Occurs when the nares are partially blocked due to the presence of exudate, making respirations noisy.
- Runny nose may or may not be present.
- Stuffiness can occur from overzealous suctioning of the nose at birth.

Scoring: 1 = If any nasal noise.

Sneezing

Scoring: 1 = If the infant sneezes 4 or more times in a row.

RESPIRATORY RATE: OBSERVATION

- The infant must be quieted if crying is present.
- When counting respirations, a hand may be placed on the infant's back, side, or chest, or by direct observation of the chest and abdominal area.
- Respirations must be counted for a FULL MINUTE.

Respiratory Rate

Scoring: 2 = RR >60/minute.

Poor Feeding

- Scoring: 2 =
- Infant demonstrates excessive sucking prior to a feeding yet sucks infrequently while feeding and takes a small amount of formula.
 - Infant demonstrates an uncoordinated sucking reflex (difficulty sucking and swallowing).
 - Infant continuously gulps the formula while eating and stops frequently to breathe.
 - Inability to close mouth around bottle.
 - Feeding takes more than 20 minutes.

When scoring for feeding: must base score on how the infant previously fed.

Regurgitation/Vomiting

Scoring: 2 = For frequent regurgitation (vomits whole feeding or vomits 2 or more times during feed) not associated with burping.

Loose Stools

Scoring: 2 = If infant has a stool that is half liquid and half solid.

A liquid stool without a water ring on the diaper should also be scored as a loose stool.

When repeating a score within 1 hr pc: use the same stools score obtained ac.

Weight

Scoring: 2 = If current weight \leq 90% of birth weight. Continue to score 2 until infant gains weight and is >90% of birth weight.

EXCESSIVE IRRITABILITY: OBSERVATION

- Distinct from, but may occur in conjunction with, crying.
- Marked by frequent grimacing, excessive sensitivity to sound and light.
- Infant becomes fussy or irritable with light, touch, or handling despite attempt to console.

Excessive Irritability

Scoring: 1 = Consoling calms infant in 5 or fewer minutes.
 2 = Consoling calms infant in 6–15 minutes.
 3 = Consoling takes more than 15 minutes, or no amount of consoling calms child.

REGURGITATION/VOMITING

Regurgitation is the effortless return of gastric or esophageal contents from the infant's mouth. It is not unusual for newborn infants to regurgitate during burping.

